EOM QUALITY MEASURES GUIDE

Version 1.2

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Revision History

Revision #	Revision Date	Description of Change
1.0	05/01/2023	Initial Version
1.1	01/15/2025	Updated 'Denominator' to 'Denominator (eligible population);' 'Denominator exclusion' to 'Denominator Exclusion (eligible population exclusion)', 'Numerator' to 'Numerator (performance met)' and 'Denominator Exception' to 'Denominator exception (eligible population exception)' throughout document. Section 1.2 Participant-Reported Measures: Added information regarding the reporting completeness threshold. Added information about ePRO reporting being used for reporting EOM-5 but not for EOM-4a and EOM-4b.. Table 2 Planned EOM Performance Years and Submission Windows: Added PP10, PP11, PP12 and PP13. Table 3 Cohort 1 EOM Measure Phase-in: Updated from "Performance Periods 2-9" to "Performance Periods 2-13" Added Table 4 Cohort 2 EOM Measure Phase-in Table Added Section 4.6 EOM Quality Measure Abstraction Tool
1.2	06/06/2025	Updated Appendix A EOM-6 measure name from "EOM-6: Patient-Reported Experience of Care Survey" to "EOM-6: Patient-Reported Experience of Cancer Care Survey"

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Introduction

The Enhancing Oncology Model (EOM) is a Center for Medicare & Medicaid Innovation alternative payment model designed to promote high quality, person-centered care, promote better care coordination, improve access to care, reduce costs, and improve outcomes for Medicare fee-for-service (FFS) beneficiaries with cancer who receive cancer treatment. EOM builds on lessons from the Oncology Care Model (OCM) and shares certain features with OCM, including episode-based payments that financially incentivize physician group practices (PGPs) to improve care and lower costs.

EOM participants are oncology PGPs that prescribe and administer cancer therapy for included cancer types. The model is centered on 6-month episodes of care triggered by the receipt of a qualifying Initiating Cancer Therapy for an included cancer type. Seven cancer types are included in the model:

1. Breast cancer[1]
2. Chronic leukemia
3. Lung cancer
4. Lymphoma
5. Multiple myeloma
6. Prostate cancer[1]
7. Small intestine/colorectal cancer

Quality measures are one key mechanism that the Centers for Medicare & Medicaid Services (CMS) use to verify clinical improvements, assess patient health outcomes and appropriate coordination of care, and ensure continued quality of care for patients. Quality measures are a component of the EOM performance-based payment (PBP) or performance-based recoupment (PBR) calculation. EOM adjusts the PBP or PBR for each performance period based on the EOM participant's performance on a range of quality measures. Additional information on performance periods, PBP/PBR is also available in the EOM Payment Methodology document.

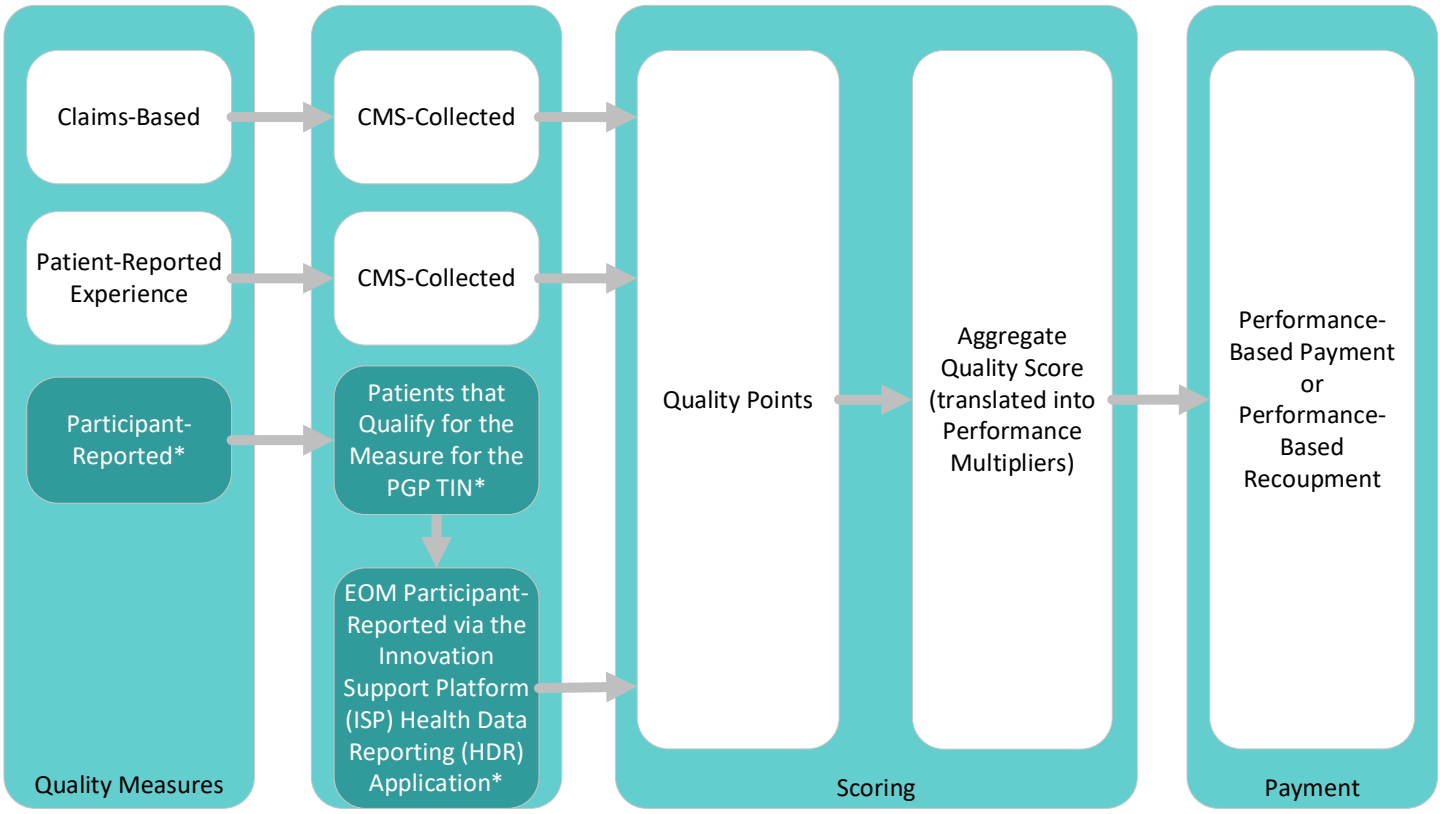
This guide provides EOM participants with the information described below:

- Section 1 provides a high-level overview of the measures selected for EOM. This section provides foundational information, including measures that are reported by EOM participants, as well as measures that are administered or calculated by CMS.
- Section 2 provides guidance on the submission of quality measure results. This section covers how to identify qualifying patients within the PGP TIN for EOM quality measure reporting; how to review quality measure results that are reported via the Innovation Support Platform (ISP) Health Data Reporting (HDR) application for each performance year.
- Section 3 gives a high-level overview of how quality measure results are used to inform the PBP and PBR, including the application of the performance multiplier.
- Section 4 provides an overview of EOM supporting documents related to quality measures.
- Section 5 contains additional EOM program resources for quality measure reporting, including links to relevant web sites and contact information for support.

Note: All documents referenced within this guide are located on EOM Connect.

An overview of the EOM quality measures that will be covered in this guide is provided in Figure 1.

Figure 1: EOM Quality Measures Overview



* The EOM Participant is responsible for reporting these items.

Section 1: EOM Quality Measures Overview

The EOM quality strategy focuses on measures from the following domains: patient experience, avoidable acute care utilization, management of symptoms and toxicity, management of psychosocial health, and management of end-of-life care. In selecting specific measures, CMS prioritizes measures that reflect national priorities for quality improvement and patient-centered care consistent with Section 1890(b)(7)(B) of the Act, as well as outcomes-based measures. Outcomes-based measures, including those collected from patients, minimize EOM participant burden where possible, and align with the CMS and Innovation Center quality strategy. The quality measure set is similar to measures included in OCM. CMS will continue to explore opportunities to update the quality measure set over time in alignment with the principles and domains outlined above as new measures emerge.

EOM quality measure performance rates will be calculated according to the specifications for each measure. Performance rates for claims-based measures (EOM-1, EOM-2, and EOM-3) will be calculated

using Medicare administrative data only. Performance rates for the patient-reported experience of care measure (EOM-6) will be calculated using the survey data collected by the Implementation and Monitoring Contractor (IMC) and a methodology agreed upon by the IMC and CMS. Performance rates for EOM participant reported measures (EOM-4 and EOM-5) will be calculated using data submitted via the ISP HDR application by the EOM participants.

To the extent possible, EOM uses existing data such as claims data or data collected for other CMS programs as part of its PBP or PBR calculation to reduce burden on EOM participants. Additional information regarding these data sources is provided in Section 1.1, Section 1.2, and Section 1.3.

Table 1: Quality Measures for Determination of Performance-Based Payment

Measure Title	EOM Measure Number	Domain	Measure Source	Type of Reporting by EOM Participant
Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy (OP-35 Respecified)	EOM-1	Avoidable acute care utilization	Claims-based	None. Calculated by CMS using Administrative Data
Proportion of Patients who Died who Were Admitted to Hospice for 3 Days or More	EOM-2*	Management of end-of-life care	Claims-based	None. Calculated by CMS using Administrative Data
Percentage of Patients who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life	EOM-3†	Management of end-of-life care	Claims-based	None. Calculated by CMS using Administrative Data
Pain Assessment and Management Set: a) Oncology: Medical and Radiation - Pain Intensity Quantified (NQF 0384; CMS Quality ID # 143) b) Oncology: Medical and Radiation - Plan of Care for Pain (NQF 0383; CMS Quality ID #144)	EOM-4^ (composed of EOM-4a and EOM-4b)	Management of symptoms toxicity	EOM Participant -reported	Reported in aggregate across all patients

* Please note that this measure was adapted from a measure endorsed by the National Quality Forum (NQF) a combination of NQF 0215 and NQF 0216. The measure specifications were changed for use in the EOM. NQF has not reviewed or approved the revised measure specifications.

† Please note that this measure was adapted from an NQF-endorsed measure (NQF 0210); the measure specifications were changed for use in the EOM. NQF has not reviewed or approved the revised measure specifications

^ The Merit-based Incentive Payment System (MIPS) specifications for the 2025 performance year were used to populate the measure description, denominators (eligible population), numerators (performance met) and (where applicable) denominator exclusions and denominator exceptions (eligible population exception) in this table. The measure specifications are released annually and any updates to the specifications will also be reflected here.

Measure Title	EOM Measure Number	Domain	Measure Source	Type of Reporting by EOM Participant
Preventive Care and Screening: Screening for Depression and a Follow-Up Plan (NQF 0418; CMS Quality ID #134)	EOM-5^	Management of psychosocial health	EOM Participant -reported	Reported in aggregate across all patients
Patient-Reported Experience of Cancer Care Survey (PECCS)	EOM-6	Patient Experience	Patient-reported	None. Patient-reported; CMS fields survey

1.1 Claims-Based Measures

CMS selected a set of claims-based measures to be used in pay-for-performance. Table 1 provides an overview of the quality measures, the data source for each measure, and the reporting requirements associated with each measure. While the claims-based measures are based on National Quality Forum (NQF) or Outpatient (OP) measure specifications, they have been respecified and tailored to EOM.

Performance rates for claims-based measures used in pay-for-performance are calculated by CMS using only Medicare administrative data and scored based on performance compared to national historical Medicare claims data for EOM participants and non-EOM oncology PGPs. The claims-based measures are limited to EOM attributed beneficiaries. The detailed specifications are available on EOM Connect.

EOM participants are not responsible for reporting data related to these quality measures; CMS uses claims data to monitor EOM participant performance and calculate the performance rates.

1.2 Participant-Reported Measures

CMS selected a set of participant-reported measures to be used for pay-for-performance (Table 1). The participant-reported measures are EOM-4 (comprised of EOM-4a and EOM-4b) and EOM-5. **All participant-reported measures are reported at the aggregate level, meaning the EOM Participant will combine the measure results for each encounter (EOM-4) or patient (EOM-5) and then add those results together to submit.** The aggregate measure results are reported annually via the CMS ISP HDR application as described in Section 2. To minimize EOM participant reporting burden and to align with the CMS and the Innovation Center's quality strategy, the participant-reported quality measures will follow the MIPS Clinical Quality Measure (CQM) specifications and guidelines for reporting where feasible, including annual reporting requirements. In alignment with MIPS, the EOM participant-reported quality measure reporting completeness threshold will be 75 percent of the denominator (eligible population) eligible encounters or patients. This completeness threshold is intended to provide some flexibility if beneficiaries who should be included are missed, but this is not intended to support sampling of beneficiaries. EOM-4 and EOM-5 will

^ The Merit-based Incentive Payment System (MIPS) specifications for the 2025 performance year were used to populate the measure description, denominators (eligible population), numerators (performance met) and (where applicable) denominator exclusions and denominator exceptions (eligible population exception) in this table. The measure specifications are released annually and any updates to the specifications will also be reflected here.

not be scored against the published MIPS benchmarks. EOM has established benchmarks and scoring methodology which is available in section 7.2.2 of the EOM Payment Methodology.

To streamline data collection and in alignment with other model requirements, participants may consider using their electronic Patient Reported Outcomes (ePROs) to collect data for encounters for EOM-5. To include an ePROs assessment as part of the EOM-5 depression screening reporting, the assessment must be an age-appropriate standardized depression screening tool (e.g., the Patient Health Questionnaire [PHQ]) and must be completed on the date of the encounter, or up to 14 days prior to the encounter. Depression screenings completed more than 14 days prior to or after the encounter will not count towards EOM-5 reporting. If the depression screening information submitted through ePROs is positive, a follow-up plan must be documented on the date of the encounter. Use of ePROs depression screening is allowable when the ePRO screening and results are integrated within the electronic medical record (EMR). EOM participants will still need to report this data as part of the quality measure submission requirements via the HDR. ePROs is not an applicable form of data collection for EOM-4 reporting at this time as EOM-4a and EOM-4b require the assessment of pain to be completed during the encounter (ePROs administration generally may not be aligned to that timing).

Additional EOM-specific reporting requirements applicable to the patient-based and encounter-based measures can be found in Section 2.3.2 and Section 2.3.3.

1.3 Patient-Reported Experience Measure

CMS will use a multi-item survey to assess patients' experience with cancer care for each EOM Participant. Survey items used in the calculation of the patient-reported experience measure for the PBP or PBR calculation will be based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for cancer drug therapy [CAHPS Cancer Care Survey: Drug Therapy (ahrq.gov)]. Additional survey items will be drawn from various validated instruments, including, but not limited to, items from the CAHPS Cancer Care Supplemental Survey [CAHPS Cancer Care Supplemental Items (ahrq.gov)] and from other validated surveys to assess end-of-life and hospice care (CAHPS Hospice Survey | CMS). These additional survey questions will be used to support evaluation of EOM, but these items will not be used for scoring purposes. The patient experience survey will be administered by the IMC each wave to a sample of the beneficiaries who received cancer care at each EOM participant in a 6-month period. More information about how survey waves are used in scoring EOM-6 by performance period is available in section 7.2.3, Table 15, of the EOM Payment Methodology.

Performance rates for the patient-reported experience measure will be calculated for pay-for-performance using aggregated composite-level scores to create one summary score of "patient experience of care." As noted above, the IMC will collect the survey data.

Section 2: EOM HDR Application

EOM participants will use a centralized reporting platform, the ISP which contains the HDR application. The EOM HDR application is a web-based data submission and collection tool that EOM participants will use to submit data, including practice-level quality measures, beneficiary-specific clinical data elements (CDEs), and beneficiary-specific sociodemographic data elements (SDEs). A separate user manual for the EOM

HDR application is available on the Resource page of the Innovation Center Portal and EOM Connect for EOM participants

EOM participants are required to submit aggregate quality measure data via the HDR application. The intent of Section 2 is to educate EOM participants on the requirements for reporting aggregate quality measure results via the HDR. The following section provide overview of the reporting requirements:

- Section 2.1 covers the Performance Years for reporting
- Section 2.2 covers the annual data reporting requirements for EOM-4a, EOM-4b, and EOM-5
- Section 2.3 covers measure-specific data reporting requirements

2.1 EOM Performance Years

Each performance year begins January 1 and ends December 31, as shown in Table 2. EOM participants will have January and February of the year following the performance year to report quality measure results via the HDR for that performance year. Participants will have an opportunity to gain familiarity with reporting via the EOM HDR application prior to each reporting period beginning.

Note:

- **Cohort 1:** Reporting of participant-reported quality measures is required to begin with the 2024 performance year, reported in January and February 2025.
- **Cohort 2:** Reporting of participant-reported quality measures is required to begin with the 2026 performance year, reported in January and February 2027.

Table 2: Planned EOM Performance Years and Submission Windows

Performance Period (Based on Episode Initiation Dates)	Performance Years	Aggregate Measure Result Submission Windows
Performance Period 1	July–December 2023	N/A
Performance Period 2 Performance Period 3	January–December 2024	January and February 2025*
Performance Period 4 Performance Period 5	January–December 2025	January and February 2026*
Performance Period 6 Performance Period 7	January–December 2026	January and February 2027
Performance Period 8 Performance Period 9	January–December 2027	January and February 2028
Performance Period 10 Performance Period 11	January–December 2028	January and February 2029
Performance Period 12 Performance Period 13	January–December 2029	January and February 2030
Performance Period 13	January–July 2030	N/A

*Note: Cohort 2 reporting of participant-reported measures is not required for performance years 2024 or 2025.

Table 3 summarizes the approach for phasing in the measures over each performance period for cohort 1. Table 4 summarizes the approach for phasing in the measures over each performance period for cohort 2. The performance multiplier in the first performance period will include the three claims-based measures (EOM-1, EOM-2, and EOM-3) and the patient-reported measure (EOM-6). The performance multiplier in the second performance period and after, will include all six quality measures listed in Table 1.

Note that the EOM participant-reported measures (EOM-4 and EOM-5) *are not included* in the first performance period scoring.

Table 3: Cohort 1 EOM Measure Phase-in

EOM Measure Number	Performance Period 1	Performance Periods 2-13
EOM-1	YES	YES
EOM-2	YES	YES
EOM-3	YES	YES
EOM-4	NO	YES
EOM-5	NO	YES
EOM-6	YES	YES
# Measures	4	6

Table 4: Cohort 2 EOM Measure Phase-in

EOM Measure Number	Performance Periods 1-4	Performance Period 5	Performance Periods 6-13
EOM-1	NO	YES	YES
EOM-2	NO	YES	YES
EOM-3	NO	YES	YES
EOM-4	NO	NO	YES
EOM-5	NO	NO	YES
EOM-6	NO	YES	YES
# Measures	0	4	6

2.2 Reporting of EOM Participant Reported Quality Measure Results

EOM participants are required to report aggregate quality measure results for all patients that qualify for the measure for the PGP TIN using the MIPS Clinical Quality Measure specifications (CQMs). EOM pools will have all of their episodes combined and treated as if all the pool's episodes belong to one participant for the purposes of quality scoring. This means that the numerator (performance met) and denominator (eligible population) for each participant in the pool will be summed before calculating pooled performance rates for each measure. For the quality measures reported for EOM, as indicated in Table 1, EOM participants are required to report aggregate measure results for EOM-4a, EOM-4b, and EOM-5 for each performance year. EOM participants are required to:

- Report the denominator (eligible population) for each measure

- Report the denominator exclusion (eligible population exclusion) (if applicable) for each measure
- Report the numerator (performance met) for each measure
- Report the numerator exclusion (performance met exclusion) (if applicable) for each measure
- Report the denominator exception (eligible population exception) (if applicable) for each measure

EOM participants have access to detailed specifications which will provide information on all clinical data required for quality measure calculations. The detailed specifications are located in the MIPS CQM for each measure and the data elements and corresponding codes are located in the MIPS CQM Single Source for each measure. These documents are updated annually and released at the end of the year prior to the performance year. For example, the documents that will be used for the performance year that begins January 1, 2024, and ends December 31, 2024, were posted late 2023. Participants will be notified when these documents are available for each performance year.

2.3 Measure-Specific Reporting Requirements

The EOM Quality Measures include populations that contain criteria used to calculate the measure performance rate. While not all populations will be used in each measure, the available measure populations are:

- Denominator (Eligible Population)
- Denominator Exclusion (Eligible Population Exclusion)
- Numerator (Performance Met)
- Numerator Exclusion
- Denominator exception (eligible population exception)

EOM quality measures encompass both patient-based (Section 2.3.2) and encounter-based (Section 2.3.3) measures as outlined below.

2.3.1 Definitions

- **Denominator (Eligible Population)**: – The *Denominator (eligible population)* refers to all events (e.g., patients, visits) to be evaluated by a specific performance measure that shares a common set of specified characteristics within a specific measurement set to which a given measure belongs. Details often include information based on specific age groups, diagnoses, diagnostic and procedure codes, and enrollment periods. Different measures within a measure set may have different *Denominators (eligible populations)*.
- **Denominator Exclusion (Eligible Population Exclusion)**: Events (e.g., patients, visits) that should be removed from the measure *Denominator (eligible population)* before determining if *Numerator (performance met)* criteria are met. *Denominator Exclusions (Eligible Population Exclusion)* are used to help narrow the *Denominator (eligible population)* (e.g., patients diagnosed with metastatic cancer would be listed as a *Denominator Exclusion (Eligible Population Exclusion)* for a measure requiring a primary diagnosis).
- **Numerator (Performance Met)** : The Numerator (performance met) criteria are the processes or outcomes expected for each patient, procedure, or other unit of measurement defined in the *Denominator (eligible population)* (e.g., a *Numerator (performance met)* listing the number of visits where the current medication list was documented and a *Denominator (eligible population)* indicating the number of visits in a specific time period).

- **Numerator Exclusion:** *Numerator Exclusions* are generally used when the improvement notation is a "lower score indicates better quality." Numerator exclusions remove events from the numerator (performance met) population while retaining them in the denominator (eligible population). For example, a *Numerator (performance met)* listing at least one short-term acute care hospital admission and a *Numerator Exclusion* for patients admitted for certain cancer-related surgeries.
- **Denominator Exception (Eligible Population Exception):** *Denominator exceptions* (eligible population exceptions) are those conditions that should remove a patient, procedure, or unit of measurement from the *Denominator (eligible population)* of the performance rate only if the *Numerator (performance met)* criteria are not met. *Denominator exceptions (eligible population exceptions)* allow for adjustment of the calculated score for those participants with higher risk populations. *Denominator exceptions (eligible population exceptions)* allow for the exercise of clinical judgment and should be specifically defined where capturing the information in a structured manner fits the clinical workflow. Generic *Denominator exception (eligible population exception)* reasons fall into three general categories:
    - Medical reasons (e.g., contraindicated, drug allergy, treatment changed)
    - Patient reasons (e.g., drug declined, financial problem, refusal of treatment)
    - System reasons (e.g., drug not available/out of stock, patient transfer, loss of benefits)

**Please note when denominator exceptions (eligible population exceptions) (medical, patient, and/or system reasons for not achieving a quality action) are applicable to a measure, the denominator exceptions (eligible population exceptions) are only applied when the quality action is not performed.

2.3.2 Encounter-Based Measures

Measures that evaluate the care during a patient-provider encounter and assign the encounter to one or more populations are called **encounter-based measures**. One of the EOM participant-reported measure specifications is encounter-based (EOM-4) and is composed of two components (EOM-4a and EOM-4b). In an encounter-based measure, the encounter is identified in the denominator (eligible population), and each qualifying encounter during the performance year is to be reported separately for that patient. Please reference the detailed code lists available in the "MIPS CQM Single Source" for specific qualifying encounter codes for each encounter-based measure.

2.3.3 Patient-Based Measures

Measures that evaluate the care of a patient over a period of time and assign the patient to membership in one or more measure populations are called patient-based measures. One of the EOM participant-reported measure specifications is patient-based (EOM-5). **All the information in the patient record referenced in the measure must be considered when calculating a patient-based measure for each performance year.** This includes care provided by any clinician at the practice, regardless of if the clinician is an EOM Practitioner. The criteria for inclusion of a patient in a measure population may require that information from multiple encounters during that performance year be considered, but the patient should only be included in the denominator (eligible population) once per performance year.

In a patient-based measure, the patient criteria for measure inclusion are identified in the denominator (eligible population). The requirement to report measure results once per performance year may result in reporting on denominator (eligible population) eligible patients prior to completion of a measure's specified time frame to complete the appropriate care. Timeframes for delivery of clinically appropriate, high-quality care are addressed in each individual measure specification based on nationally recognized clinical guidelines. The requirement to report measure results for each measure does not change the timeframes in which high-quality clinical care may be provided.

Section 3: Determination of Performance-Based Payment or Performance-Based Recoupment

Detailed information regarding calculation of performance rates, PBR and PBP is available in the EOM Payment Methodology document. This guide provides a high-level overview of these topics.

Scoring, or the process of assigning quality points to each quality measure, is based on the EOM participants' reporting of quality measure data and/or quality performance relative to set thresholds. EOM quality measure data derived from claims, aggregate measure results reported via the ISP HDR application, and patient experience survey data, are used to calculate the quality score or Aggregate Quality Score (AQS). Once the Aggregate Quality Score (AQS) is calculated, it is translated into a performance multiplier. This performance multiplier is used as part of the PBP or PBR calculation. More information is available in Section 7 of the EOM Payment Methodology document.

Section 4: EOM Quality Measure Reporting Supporting Documents

This section provides an overview of several EOM supporting documents that:

- Section 4.1: Explains the payment methodology used to calculate EOM PBP and PBR
- Section 4.2: Lists the HCPCS and NDC codes needed to identify patients and episodes for EOM claims-based measure reporting
- Section 4.3 and Section 4.4: Provides measure specifications and patient-reported measure code lists
- Section 4.5: Helps EOM participants abstract quality measure data in preparation for reporting to the EOM ISP HDR application
- Section 4.6: FAQs available to participants

These documents are available on EOM Connect.

4.1 EOM Payment Methodology

This document includes technical details for the methodology used to calculate EOM performance rates and PBP and PBR. For each performance period, EOM participants have the potential to earn a PBP, owe a PBR, or fall into the neutral zone (neither earning a PBP nor owing a PBR.)

To determine whether an EOM participant has potentially earned a PBP, we compare the actual episode expenditures for attributed episodes (or for episodes attributed to all EOM participants) to the participant's

target amount for the performance period. EOM participants may earn a PBP if their actual episode expenditures are below their target amount (although PBPs are contingent upon quality performance and other PBP eligibility criteria detailed in the participation agreement). EOM participants owe a PBR if the actual episode expenditures are higher than the threshold for recoupment threshold. The amount of the PBR is contingent upon quality performance; that is, high performance on quality measures during the performance period may reduce the amount owed. More information about how measures are scored, how the AQS is calculated, how the performance multiplier works, and the benchmarks and scoring methodology used for the EOM quality measures is available in Section 7 of the EOM Payment Methodology.

4.2 EOM Technical Payment Resource (used for EOM Claims-based measures only)

This document includes a general list of EOM-qualifying ICD-10-CM cancer diagnosis codes in the 'Cancer Type Mapping' tab. This information will be used to:

- Identify patients that have a qualifying cancer diagnosis code

This document also includes a list of Healthcare Common Procedure Coding System (HCPCS) codes (in the 'Initiating Therapy-HCPCS Codes' tab) and National Drug Codes (NDCs) (in the 'Initiating Therapy-NDC Codes' tab) that have been identified as qualifying initiating cancer therapy codes. This information will be used to:

- Identify patients that have a qualifying initiating cancer therapy code

4.3 EOM Measure Specifications

Each measure specifications document includes Description, Guidance, Numerator (Performance Met) and Denominator (Eligible Population) definitions, and where applicable, Denominator Exclusion (Eligible Population Exclusion) and Denominator Exception (Eligible Population Exception) definitions. These narrative descriptions of the population criteria represent the data that will be used to calculate these measures. Each measure flow provides a flow chart and narrative representation of the individual EOM Measure Specifications.

4.4 EOM Participant Reported Measure Code Lists

The codes that make up the population criteria for the participant-reported measures can be found in the MIPS CQM Single Source document. Each of the participant-reported measures can be found by filtering the 'Measure ID' column to the applicable MIPS measure ID.

4.5 EOM Quality Measure Abstraction Tool

The EOM Quality Measure Abstraction Tool is an optional tool designed to aid EOM participants in the collection and calculation of aggregate quality measure data for the participant-reported measures EOM-4 and EOM-5. The tool may be used to collect data prior to manual entry into the CMMI ISP HDR application. The tool was developed in alignment with the MIPS CQM specifications; all instructions and guidance in the specifications must be followed when abstracting data into the tool.

4.6 EOM FAQ

This document includes frequently asked questions from EOM participants regarding all aspects of EOM. This document is available on EOM Connect.

Section 5: EOM Quality Reporting Program Resources

CMS EOM Website

- https://innovation.cms.gov/innovation-models/enhancing-oncology-model

EOM Connect:

- https://app.innovation.cms.gov/CMMIConnect/IDMLogin

Innovation Support Platform (ISP) Health Data Reporting (HDR) Application:

- https://portal.cms.gov

EOM Help Desk:

- EOM@cms.hhs.gov
- 1-888-734-6433, option 3

MIPS Clinical Quality Measure Specifications and Supporting Documents:

- https://qpp.cms.gov/resources/resource-library

Section 6: Acronyms and Abbreviations

Acronym	Literal Translation
AQS	Aggregate Quality Score
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CQM	Clinical Quality Measure
EOM	Enhancing Oncology Care Model
FFS	Fee-for-Service
HCPCS	Healthcare Common Procedure Coding System
HDR	Health Data Reporting
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IMC	Implementation and Monitoring Contractor
ISP	Innovation Support Platform
MIPS	Merit-based Incentive Payment System
NDC	National Drug Code
NQF	National Quality Forum
PBP	Performance-Based Payment
PBR	Performance-Based Recoupment

Appendix A

Table A-1: EOM Measure Description and Population Summary

Measure Name	Measure Description	Denominator (Eligible Population) Summary	Denominator Exclusions Summary	Numerator (Performance Met) Summary	Denominator Exception (Eligible Population exception)s) or Numerator Exclusions Summary
EOM-1: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy (Respecified OP-35)**	The Centers for Medicare & Medicaid Services (CMS), through its Center for Medicare and Medicaid Innovation (The Innovation Center), respecified a quality measure to assess complications occurring for cancer patients receiving outpatient chemotherapy. This measure is intended for practices participating in the Enhancing Oncology Model (EOM).	The denominator is six-month patient-episodes for patients with a diagnosis of one of the following seven specific cancer types and receiving chemotherapy treatment. The seven cancer types are: breast cancer, chronic leukemia, lung cancer, lymphoma, multiple myeloma, prostate cancer, and small intestine/colorectal cancer.	• Patients who do not have continuous enrollment in Medicare FFS Part A and Part B in the 30 days after the chemotherapy treatment (with the exception of enrollment truncation due to death). • Patients with CAR-T therapy at any point during the episode.	The numerator/outcome definitions are the number of patients admitted at least once as an inpatient or seen in an ED within 30 days after a qualifying chemotherapy treatment in an outpatient setting for one of ten qualifying conditions. The ten conditions are anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, and sepsis, and must be in the primary discharge diagnosis position or as a secondary diagnosis with cancer as primary diagnosis.	**Numerator Exclusions:** Qualifying chemotherapy claims occurring less than 31 days before the end of the episode will not be considered as chemo events that could start a 30-day outcome assessment period.

Measure Name	Measure Description	Denominator (Eligible Population) Summary	Denominator Exclusions Summary	Numerator (Performance Met) Summary	Denominator Exception (Eligible Population exception)s) or Numerator Exclusions Summary
EOM-2* Proportion of Patients who Died who Were Admitted to Hospice for 3 Days or More**	Proportion of episodes ending in death in which the beneficiary was enrolled in hospice for at least 3 days immediately before death	Patients who died during the episode	None	All patients who were enrolled in hospice for at least 3 days immediately before death, for beneficiaries in the denominator population for this measure	None
EOM-3†: Percentage of Patients who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life**	Percentage of patients who died during the episode receiving chemotherapy in the last 14 days of life	Patients who died during the episode	None	Patients who received chemotherapy in the last 14 days of life	None
EOM-4a^: Oncology: Medical and Radiation – Pain Intensity Quantified (NQF 0384: CMS Quality ID # 143)	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy	None	Patient visits in which pain intensity is quantified	None

* Please note that this measure was adapted from an NQF-endorsed measure (combination of NQF 0215 and NQF 0216). The measure specifications were changed for use in the Enhancing Oncology Model. NQF has not reviewed or approved the revised measure specifications.

† Please note that this measure was adapted from an NQF-endorsed measure (NQF 0210). The measure specifications were changed for use in the Enhancing Oncology Model. NQF has not reviewed or approved the revised measure specifications

^ The MIPS specifications for the 2025 performance year were used to populate the measure description, denominators (eligible population), numerators (performance met) and (where applicable) denominator exclusions (eligible population exclusion) and denominator exceptions (eligible population exception) in this table. The measure specifications are released annually and any updates to the specifications will also be reflected here.

**For EOM Measure, the term chemotherapy refers to all cancer treatments included in the EOM initiating cancer therapies lists.

Measure Name	Measure Description	Denominator (Eligible Population) Summary	Denominator Exclusions Summary	Numerator (Performance Met) Summary	Denominator Exception (Eligible Population exception)s) or Numerator Exclusions Summary
EOM-4b^: Oncology: Medical and Radiation – Plan of Care for Pain (NQF 0383: CMS Quality ID # 144)	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain	All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain	None	Patient visits that included a documented plan of care to address pain	None
EOM-5^: Preventive Care and Screening: Screening for Depression and a Follow-Up Plan (NQF 0418: CMS Quality ID # 134)	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter	All patients aged 12 years and older at the beginning of the performance period with at least one qualifying encounter during the performance period	Documentation stating the patient has had a diagnosis of bipolar disorder	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter	**Denominator Exceptions:** • Patient reason(s) • Medical reason(s)
EOM-6: Patient-Reported Experience of Cancer Care Survey	Please refer to section 7.3.3 of the "EOM Payment Methodology" document	N/A	N/A	N/A	N/A

^ The MIPS specifications for the 2025 performance year were used to populate the measure description, denominator (eligible population), numerator (performance met) and (where applicable) denominator exclusions (eligible population exclusions) and denominator exceptions (eligible population exceptions) in this table. The measure specifications are released annually and any updates to the specifications will also be reflected here.